Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS659HOS	A. BUILDING _____ B. WING _____	11/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ROSE DOMINICAN HOSPITAL-DE LIMA	102 E LAKE MEAD DR HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 27469 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 11/3/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00023472 was unsubstantiated Complaint #NV00023473 was substantiated with deficiencies cited. (See Tag S0310) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified.	S 000		
S 310 SS=E	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS659HOS	A. BUILDING _____ B. WING _____	11/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ROSE DOMINICAN HOSPITAL-DE LIMA	102 E LAKE MEAD DR HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 310	Continued From page 1 accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Surveyor: 27469 Based on interview and record review, the facility failed to provide an accurate assessment of the patient based on the testing completed. 1. Patient #2 was diagnosed with attempted suicide related to an intentional overdose of benzodiazepines. The urine drug screen obtained in the emergency room indicated there were no benzodiazepines found in the urine. All documentation regarding the subsequent Legal 2000 hold was related to the alleged intentional benzodiazapine overdose. Severity: 2 Scope: 2	S 310		